STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155319	A. BUILDING	COMPLETED	
		1553 19	B. WING		04/16/2012
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE 11TH ST	
CLINTO	N GARDENS		CLINT		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
K0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICERCT)	DATE
10000					
	Δ Life Safety Co	ode Recertification	K0000	The creation and submission	of
	I	sure Survey was		this Plan of Correction does r	
		he Indiana State		constitute an admission by th	
	Department of			provider of any conclusion se forth in the statement of	l
	I	h 42 CFR 483.70(a).		deficiencies, or of any violation	on of
	accordance with	11 42 CFK 403.70(a).		regulation. This provider	
	Survey Date: 0	4/16/12		respectfully requests that the	
	Survey Date: 04/16/12			2567L Plan of Correction be considered the Letter of Cred	ihle
				Allegation and requests a Pos	
	Facility Number: 000212 Provider Number: 155319			Certification Review of paper	
				compliance on or after May 1	6,
	AIM Number: 1	100285040		2012.	
	 Surveyor: Bridg	net Rrown Life			
	Safety Code Spe				
	Safety Code Spi	ecialist			
	At this Life Safe	ety Code survey,			
	Clinton Garden	s was found not in			
	compliance wit	h Requirements for			
	Participation in				
	Medicare/Medi	caid, 42 CFR			
	Subpart 483.70)(a), Life Safety			
	from Fire and t	he 2000 edition of			
	the National Fir	e Protection			
	Association (NF	PA) 101, Life Safety			
	· ·	410 IAC 16.2. The			
		g was surveyed			
	1	9, Existing Health			
	Care Occupanc	-			
	The was detern	nined to be of Type			
		iction and was fully			
		,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155319 A. BUILDING B. WING		01 	COMPL: 04/16/	ETED			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842				
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E.	(X5) COMPLETION DATE
	alarm system we detection in the spaces open to facility has the and had a cens of this survey. Quality Review by Force Specialist-Med The facility was compliance with aforementioned.	e corridors and the corridors. The capacity for 113 us of 85 at the time Robert Booher, Life Safety dical Surveyor on 04/23/12.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155319	B. WING			04/16/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			375 S 1	1TH ST		
	I GARDENS			CLINTO	DN, IN 47842		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0018 SS=E	NFPA 101 LIFE SAFETY Corpors protecting than required enexits, or hazardo doors, such as the solid-bonded corresisting fire for a sprinklered building resist the passage impediment to the Doors are provided keeping the door meeting 19.3.6.3 Roller latches are regulations in all Based on obserting interview, the feensure corridor from impediment of 7 smoke condeficient practiculations, staff and control in the staff a	ODE STANDARD corridor openings in other closures of vertical openings, sus areas are substantial nose constructed of 1¾ inch re wood, or capable of at least 20 minutes. Doors in ings are only required to ge of smoke. There is no re closing of the doors. red with a means suitable for relosed. Dutch doors relosed. Dutch doors relosed. Dutch doors relosed. The relation of the suitable for relosed. Dutch doors relosed. Dutch doors relosed. The relation of the suitable for relosed. The relation of the relation of the suitable for relosed. The relation of the relation of the suitable for relosed. The relation of the rela	K00	TAG	It is the intent of the facility to ensure corridor doors are free from impediments when closing. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?*The self-closing dou doors from the main dining roo will be removed as part of the current renovation of the facility. How other residents having the potential to be affected by the same deficient practice be identified and what corrective	(s) ble m	DATE 05/16/2012
	Based on obser	vation with the			action(s) will be taken?*All		
	maintenance di				residents have the potential to	be	
					affected.*There were no other areas identified.What measure		
		30 p.m., the self			will be put into place or what	ંગ	
	_	door set separating			systemic changes will be made	e to	
		om the main dining			ensure that the deficient practi	ce	
		close and latch into			does not recur?*The Maintena	nce	
		when tested with			Director will ensure the self-closing doors are		
	the maintenanc	ce director. The			Sch-closing doors are		

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	OF CORRECTION IDENTIFICATION NUMBER: 155319	A. BUILDING B. WING	COMPLETED 04/16/2012
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION DATE
	doors were twice released from magnets holding the doors open and allowed to close. They failed each time when one door hit the other and prevented both from latching into the door frame. The maintenance director said at the time of observation, the doors were always a problem. 3.1–19(b)	removed.How the corrective action(s) will be monitored to ensure the deficient practice not recur, i.e., what quality assurance program will be pinto place?*To ensure compliance, the Maintenanc Director is responsible to enthe dining room is compliant Life Safety Standards prior to doors being removed. The results of the removal will be reviewed by the CQI Commoverseen by the ED. If a threshold of 100% is not achieved, an action plan will developed to ensure compliance.	e will e sure to o the e stittee

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE (COMPL		
ANDILAN	OF CORRECTION	155319	A. BUII	LDING	01	04/16/	
		133319	B. WIN			04/10/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CLINTON	N GARDENS		375 S 11TH ST CLINTON, IN 47842				
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG K0021 SS=E	NFPA 101 LIFE SAFETY Corrections and expensions are as the sum of	ODE STANDARD xit passageway, stairway ontal exit, smoke barrier or enclosure is held open only ged to automatically close all one or throughout the facility of: nanual fire alarm system; etectors designed to detect through the opening or a detection system; and sprinkler system, if installed. .8.2 rvation and acility failed to doors to hazardous a kitchen were held evices which would sto close upon e fire alarm system. practice affects and 20 or more the dining room.	K00	TAG	It is the intent of the facility to ensure doors to hazardous are such as a kitchen are held ope only by devices arranged to automatically close all such do by zone or throughout the faci upon activation of a fire alarm system, local smoke detectors an automatic sprinkler system What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *The trash receptacle was immediately removed. *An inservice was held with all dietary staff, 04/27/12 and 04/28/12, by the Certified Dietary	eas en oors lity	
	maintenance di	irector on			Manager to educate regarding the		
		15 p.m., the self			importance of not impeding doors by placing receptacles, and the like,		
	closing door to	•			to prevent them from closing upon		
	between the di				activation of a fire alarm system.		
	kitchen was pre	-			*The self-closing double doors to th	ie	
	Michiell Was pic				l .		<u>[</u>]

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION 01	l í	E SURVEY PLETED
ANDILAN	OI CORRECTION	155319	A. BUILDING	<u> </u>		6/2012
		.03010	B. WING	ADDRESS STATE STATE		
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP (CODE	
CLINITON	N GARDENS			11TH ST ON, IN 47842		
				OIN, IIN 77 072		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG			DATE
	_	trash receptacle		service opening between	· ·	
	was left in the	path of the door's		room and kitchen will be a properly close. How other	•	
	swing leaving i	t open eight inches.		having the potential to be		
	The maintenan	ice director said at		by the same deficient prac		
	the time of obs	servation, the door		be identified and what co		
		en closed if staff		action(s) will be taken?		
		e receptacle there.		*All residents have the po	tential to	
		servation with the		be affected.		
	maintenance d			*An inservice was held wit	th all	
				dietary staff, 04/27/12 and		
		:15 p.m., the self		04/28/12, by the CDM to		
	closing double			regarding the importance		
	service openin	g between the		impeding doors by placing		
	dining room ar	nd kitchen were		receptacles and the like to them from closing upon a	•	
	prevented fron	n closing when one		a fire alarm system. What		
	door hit the as	tragal of the first		will be put into place or w		
		and left a half inch		systemic changes will be n		
		itenance director		ensure that the deficient p		
		e of observation,		does not recur?		
				*The CDM shall perform		
		ld have closed if the		audits/facility rounds daily	y to	
	second door h	ad closed first.		monitor that the doors are		
				impeded by receptacles a		
	3.1-19			*Staff found not to respon		
				promptly and/or not conti	inue to	
				follow compliance will be		
				immediately addressed. *The Maintenance Directors	or will	
				monitor the self-closing de		
				part of routine Preventation		
				Maintenance rounds. How	v the	
				corrective action(s) will be	2	
				monitored to ensure the o	deficient	
				practice will not recur, i.e.	, what	
				quality assurance program	n will be	
				put into place?		
				*To ensure compliance, th	ne CDM is	
			- 1	1		I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155319	B. WING		04/16/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		11TH ST	
CLINITON	N GARDENS			ON, IN 47842	
CLINTON	N GARDENS		CLININ	JN, IN 47642	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				responsible for the completion	
				Routine Compliance Rounds CQI to	ol
				weekly to ensure doors are not held	d
				open by items other than the	
				closure, times 4 weeks, bi-monthly	
				times 2 months, and then quarterly	
				until continued compliance is	
				maintained for 2 consecutive	
				quarters. The results of these audit	S
				will be reviewed by the CQI	
				committee overseen by the ED. If a	
				threshold of 95% is not achieved, an	1
				action plan will be developed to	
				ensure compliance.	
				*To ensure compliance, the Maintenance Director will complete	
				Preventative Maintenance Rounds	
				CQI tool weekly to monitor proper	
				closure of the self-closing double	
				doors to the service opening	
				between the dining room and	
				kitchen, times 4 weeks, bi-monthly	
				times 2 months, and then quarterly	
				until continued compliance is	
				maintained for 2 consecutive	
				quarters. the results of these audit	s
				will be reviewed by the CQI	
				committee overseen by the ED. If a	1
				threshold of 95% is not achieved, a	ı
				action plan will be developed.	

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JETIPLE CC	ONSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155319	A. BUII	LDING	01	04/16/	
		155319	B. WIN			04/16/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CLINITON	I GARDENS				1TH ST DN, IN 47842		
					711, 111 47 042	1	
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION DATE
K0051	NFPA 101	LSC IDENTIFT ING INFORMATION)		TAU	BELIEBRELY		DATE
SS=F		ODE STANDARD					
00 1		em with approved					
	•	vices or equipment is					
		ng to NFPA 72, National Fire					
	•	rovide effective warning of the building. Activation of					
	• •	alarm system is by manual					
		on, automatic detection or					
		stem operation. Pull stations					
		g areas may be omitted					
	provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are						
		th of egress. Electronic or					
	•	f tests are available. A					
		ource of power is provided.					
	•	ms are maintained in					
		NFPA 72 and records of kept readily available.					
		annunciation of the fire alarm					
		proved central station.					
	19.3.4, 9.6						
	Based on obser	vation and	K00	051	It is the intent of the facility to		04/16/2012
	interview, the f	acility failed to			maintain fire alarm systems in accordance with NFPA 72, 19	99	
	maintain 1 of 1	fire alarm systems			edition. What corrective action(s)	50	
	in accordance v	vith NFPA 72,			will be accomplished for those		
	National Fire Al	arm Code, 1999			residents found to have been		
	Edition. NFPA	72, 1-5.2.5.2			affected by the deficient		
	requires the fire	e alarm circuit			practice?*The circuit in the fire		
	disconnecting r	means shall have a			alarm system circuit breaker listed on the directory inside the		
	red marking, sh	nall be accessible			emergency power circuit breaker		
	_	zed personnel, and			box was clearly identified and		
		ied as FIRE ALARM			marked with red marking and		
		ROL. This deficient			identified as FIRE ALARM CIRCUIT		
		affect all residents			CONTROL. How other residents		
	as well as visito				having the potential to be affected by the same deficient practice will		
	us 11011 us visite	no and stain			be identified and what corrective		
	Findings includ	Δ.			action(s) will be taken?*All resident	S	
	i mumgs metuu	<u> </u>					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE COMPI 04/16	
	PROVIDER OR SUPPLIER		375 S 1	ADDRESS, CITY, STATE, ZIP (11TH ST ON, IN 47842	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	maintenance d 04/16/12 at 3: alarm system of listed on a dire emergency pow box, however, which circuit w connected to th panel. The ma said at the time knew the fire a was connected emergency pow	20 p.m., the fire circuit breaker was ctory inside the ver circuit breaker it was unclear as actually ne fire alarm control intenance director of observation, he larm circuit breaker to generator ver but he was cify which circuit		have the potential to be affected.*There were no consideratified. What measures put into place or what systic changes will be made to end the deficient practice does recur?*The Mainenance Divisually monitor all fire all breakers listed on the direct inside the emergency power breaker boxes as clearly ideand marked with red marking dentified as FIRE ALARM (CONTROL during routine Preventative Maintenance rounds.*Circuit breakers for to have proper legible idea will be immediately marked the corrective action(s) with monitored to ensure the corrective will not recur, i.e. quality assurance program put into place?*To ensure compliance, the Maintenan Director will complete Premaintenance Rounds CQI 4 weeks, bi-monthly times and then quarterly until compliance is maintained consecutive quarters. The these audits will be review CQI committee overseen in threshold of 95% is not a an action plan will be developed.	s will be temic nsure that s not Director will arm circuit ectory ver circuit dentified king and CIRCUIT cound not intification ed. How fill be deficient in, what in will be exerciated tool, times is 2 months, continued for 2 exerciated exerciated exerciated exerciated for 2 exerciated exerciated exerciated exerciated for 2 exerciated exerciated exerciated for 2 exerciated exerciated exerciated exerciated for 2 exerciated exerciated exerciated for 2 exerciated exerciated exerciated for 2 exerciated exerciated for 2 exerciated exerciated exerciated for 2 exerciated exerciated for 2 exerciated exerciated for 2 exerciated exerciated for 2 exerciated exerciated exerciated for 2 exerciated exerciated for 2 exerciated exe	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319		LDING	onstruction 02	(X3) DATE COMPI 04/16	ETED
	PROVIDER OR SUPPLIER			375 S 1	ADDRESS, CITY, STATE, ZIP CODE 1TH ST DN, IN 47842		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
K0000	and State Licenconducted by the Department of accordance with Survey Date: 04 Facility Number Provider Number AIM Number: 1 Surveyor: Bridg Safety Code Speak Clinton Garden compliance with Participation in Medicare/Medi	th 42 CFR 483.70(a). 4/16/12 r: 000212 er: 155319 00285040 et Brown, Life ecialist ety Code survey, s was found not in th Requirements for caid, 42 CFR 0(a), Life Safety the 2000 edition of the Protection EPA) 101, Life Safety	Koo	000	The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusions forth in the statement of deficiencies, or of any violating regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Creatlegation and requests a P Certification Review of paper compliance on or after May 2012.	not his et ion of e dible ost	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BU		A. BUII	A. BUILDING B. WING O2 COMPLETED 04/16/2012			ETED	
NAME OF F	ROVIDER OR SUPPLIER		D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	I GARDENS		375 S 11TH ST CLINTON, IN 47842				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	construction are The facility has with smoke det corridors and secorridors. The capacity for 11 sof 73 at the time. The facility was compliance with aforementioned.	oe of Type V (111) and fully sprinklered. a fire alarm system section in the paces open to the facility has the 3 and had a census he of this survey. 6 found not in the					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155319	(X2) MU A. BUII B. WIN	LDING	DNSTRUCTION 02	(X3) DATE (COMPL 04/16 /	ETED
	ROVIDER OR SUPPLIER		P. W.I.V.	375 S 1	ADDRESS, CITY, STATE, ZIP CODE 1TH ST DN, IN 47842		
(X4) ID PREFIX TAG K0051	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
SS=F	A fire alarm syste components, devinstalled according effective warning building. Activat system is by man automatic detect operation. Pull spath of egress. In of tests are avail source of power systems are man NFPA 72, Nation records of mainter available. There the fire alarm systation. 18.3.4 Based on obserinterview, the firm accordance with the fire alarm systation. 18.3.4 Based on obserinterview, the firm accordance with the fire alarm systation. 18.3.4 Based on obserinterview, the firm accordance with the fire alarm systation. NFPA requires the firm accordance with the firm accordance	vation and acility failed to fire alarm systems with NFPA 72, arm Code, 1999 72, 1–5.2.5.2 e alarm circuit means shall have a nall be accessible zed personnel, and led as FIRE ALARM ROL. This deficient affect all residents ors and staff.	K00	051	It is the intent of the facility to maintain fire alarm systems in accordance with NFPA 72, 199 edition. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*The circuit in the fire alarm system circuit breaker listed on the directory inside the emergency power circuit breaker box was clearly identified and marked with red marking and identified as FIRE ALARM CIRCUIT CONTROL. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*All resident have the potential to be affected.*There were no others identified. What measures will be	99	04/16/2012

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PRINTED: 05/03/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION II	DENTIFICATION NUMBER: 155319	A. BUILDING B. WING	02 	COMPLETED 04/16/2012		
NAME OF PROVIDER OR SUPPLIER CLINTON GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
	panel. The main	O p.m., the fire cuit breaker was cory inside the er circuit breaker was unclear s actually e fire alarm control etenance director of observation, he erm circuit breaker o generator er but he was		put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*The Mainenance Director wivisually monitor all fire alarm circuit breakers listed on the directory inside the emergency power circuit breaker boxes as clearly identified and marked with red marking and identified as FIRE ALARM CIRCUIT CONTROL during routine Preventative Maintenance rounds.*Circuit breakers found not to have proper legible identification will be immediately marked. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*To ensure compliance, the Maintenance Director will complete Preventative Maintenance Rounds CQI tool, time 4 weeks, bi-monthly times 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed.	S S S S S S S S S S S S S S S S S S S		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02			COMPL	(X3) DATE SURVEY COMPLETED	
		155319	B. WIN	G		04/16/	/2012
NAME OF PROVIDER OR SUPPLIER CLINTON GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842				
PREFIX (EACH D TAG REGULAT	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)		ATE	(X5) COMPLETION DATE
SS=E LIFE SAF Electrical accordance	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2						
interview ensure ar box obse compartra a safe op 19.5.1 re with Sect requires of equipmen 70, Nation Edition. Article 37 junction I with cover box. This affect vising residents Findings Based on maintena 04/16/12 box in the barrier als was left up maintena.	Electrical wiring and equipment is in accordance with NFPA 70, National		KO	147	It is the intent of the facility to ensure attic electrical junction boxes are maintained in a sat operating condition. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? *The junction b in the attic above the smoke barrie above rooms 18 and 19 was prope covered for compliance. How other residents having the potential to b affected by the same deficient practice will be identified and what corrective action(s) will be taken?*All residents have the potential to be affected. *There we no other areas identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practic does not recur?*The Maintenance Director will visually monitor all att junction boxes to ensure they are properly covered for compliance as a part of routine Preventative Maintenance rounds quarterly or a needed when maintenance is performed in the attic. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? *To ensure compliance, the Maintenance	n fe e ox er rrly e t t re	04/27/2012

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	OF CORRECTION	IDENTIFICATION NUMBER: 155319	(X2) MULTIPLE CO A. BUILDING B. WING	02		LETED 6/2012	
NAME OF PROVIDER OR SUPPLIER CLINTON GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	connected to tl	ne junction box was he acknowledged		Director will complete Pre Maintenance Rounds CQI 4 weeks, bi-monthly time and then quarterly until c compliance is maintained consecutive quarters. The these audits will be review CQI committee overseen If threshold of 95% is not an action plan will be dev	eventative I tool, times as 2 months, continued I for 2 e results of wed by the by the ED. achieved		

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